Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PKWY. STE. G GRAND PRAIRIE, TX. 75050	MFDR Tracking #: M4-06-1895-01
Respondent Name and Box #: LUMBERMENS UNDERWRITING ALLIANCE REP. BOX # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary Taken from the Table of Disputed Services: "Pre-Authorized - #71036191-4", "Pre-Authorized - #71036191-5", "Pre-Authorized - #71036191-6", and "Pre-Authorized - #71036191-8"

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $13675.00
3. CMS 1500s
4. EOBs
5. Pre-authorization letters
6. Medical records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Carrier maintains that it paid all bills in accordance with applicable medical fee guidelines, laws, and rules in effect…."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10-15-04	97799-CP (x8 hours/units)	W1 & W9	1, 2, 3, 4, & 5	$12,750.00
10-20-04		W1 & W9		
11-9-04		V & 150		
11-19-04		V & 150		
11-22-04		V & 150		
11-23-04		V & 150		
11-29-04		V & 150		
1-20-05		NO EOB		
1-21-05		NO EOB		
1-25-05		W9		
1-26-05		W9		
1-27-05		W9		
1-28-05		W9		
1-31-05		W9		
2-1-05		W9		
2-2-05		W9		
2-3-05		W9		
11-3-04	97799-CP (x8 hours/units)	F & 510	1, 2, 3, & 6	$0.00
11-4-04				
11-5-04				
Total Due:				$12,750.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied/reduced by the Respondent with reason codes "W1" (workers' compensation state fee schedule adj.), "W9" (unnecessary medical treatment-peer review), "V" (unnecessary treatment-(with peer review), "150" (denied per insurance carrier decision), "F" (fee guideline MAR reduction), and "510" (payment determined).
2. The Requestor submitted a total of four pre-authorization letters which identified authorization of the chronic pain management program for a total of 20 sessions; to begin on 10-4-04 and end on 2-4-05. A review of these authorization letters identify that the last two authorizations were 'extensions' of the program date(s).
3. In accordance with Rule 133.307 (e) (2) (B), the Requestor submitted proof of carrier receipt of their 'request for reconsideration' via a signed U.S.P.S. certified green card and a confirmation sheet. These DOS are eligible for review.
4. Pursuant to Rule 133.301 (a), the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment or services for which the health care provider has sought and obtained pre-authorization; therefore, being that the provider did receive authorization for this rehabilitation program, it may not be denied for 'medical necessity' reasons and payment is recommended in accordance with Rule 134.202 (e) (5) (A) (ii) (E) (i) (ii).
   - 97799-CP: MAR=$125.00 per hour (if CARF)
   - 97799-CP: MAR=$100.00 per hour (not CARF)-($125.00 x 80%=$100.00)
   - 97799-CP (non-CARF) $100.00 x 8 hrs./units=$800.00
   - $800.00 x 17 DOS=$13,600.00
5. A review of the submitted documentation for these DOS state that 'patient took the usual & specific breaks'. Payment can not be made/recommended for time (s) that the patient was not actively participating in the program; i.e. 'lunch and breaks'. A 30 minute deduction is appropriate.
   - 97799-CP (non-CARF) $100.00 x 8 hrs./units=$800.00 per day - $50.00 (2- 15min. increments for lunch/breaks=30 minutes)=$750.00 per day allowance
   - $750.00 x 17 DOS=$12,750.00

6. A review of the EOB and of the Disputed Table identifies that a $775.00 payment was made for each of these DOS. Per the EOBs, the MAR fee was reduced by $25.00 from the allowable $800.00 due to a 30 minute lunch taken. A review of the submitted documentation for these DOS state that 'patient took the usual & specific breaks'. Payment can not be made/recommended for time (s) that the patient was not actively participating in the program; i.e. 'lunch and breaks'. This deduction is appropriate and this additional payment recommendation will not be made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.202, 133.307, 133.301
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $12,750.00 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

		10-23-09
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		10-23-09
Authorized Signature	Medical Fee Dispute Resolution Mgr.	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.